VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 12, 2013

Nancy Warner, Administrator
Orleans Essex VNA & Hospice
46 Lakemont Road
Newport, VT 05855-1550

Provider ID #: 477018

Dear Ms. Warner:

Enclosed is a copy of your acceptable plans of correction for the re-certification Federal survey conducted on **January 16, 2013**.

Follow up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure - FEDERAL

FEB 06 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477018	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORLEANS ESSEX VNA & HOSPICE	46 LAKEMONT ROAD NEWPORT, VT 05855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An unannounced re-certification Federal survey was conducted on 01/14/13 - 01/16/13 by the Division of Licensing and Protection. The following are Federal regulatory findings.	G 000		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation and confirmed through staff interview, the agency nurse failed to comply with acceptable professional standards of practice during the provision of wound care for 1 of 2 clients in the targeted sample. (Client #1) Findings include: 1. Per observation of a dressing change procedure on 01/14/13 at 2:30 P.M. for Client #1, who had a history of an infected wound and skin graft, the Registered Nurse (RN) failed to keep the wound free from cross contamination while dressing the wound. The nurse applied antibiotic ointment directly from the tube, three times onto the gloved hand, to the skin graft site on the right leg. After removing the soiled dressing and donning new gloves the nurse applied Eucerin lotion to the upper groin wound, in which the skin was healed and then applied antibiotic ointment, directly from the tube onto the same gloved hand, to a small open area in the lower portion of the wound. Per interview on 01/16/12 at 9:00 AM the nurse confirmed that the best practice would be to put the antibiotic ointment on a gauze from	G 121	G121 Corrective Action Plan: The surveyor findings will be reviewed with the clinical nursing staff at the next nursing staff meeting held on February 5, 2013. The Wound Care Specialist Nurse has developed an educational tool, with space for the nurse to write out individual wound care instructions, that may be left in the wound care client's home. All staff will be instructed on its use. Proper infection control will be discussed with all skilled nursing staff on 2/5/2013. Completion date 2/5/2013 POC G121 accepted 2/7/13 Joan D. Emmons RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Warner | TITLE: E.D. | (X6) DATE: 2/4/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	Continued From page 1 which to apply the antibiotics to the wounds. The clinical manager later that afternoon, confirmed that the dressing change was not done per professional standards. Ref: Basic Nursing -Theory and Practice ; Perry and Potter, The C.V Mosby Company : Dry Dressing pg. 899	G 121		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview, the agency failed to assure effective reporting and coordination of client care and services for 2 of 6 applicable clients in the sample (Client #2 & #3]. Findings include: 1. Based on record review and staff interview, agency staff failed to document that case conferences had occurred for Client #2. Per record review on 01/15/13 of Client #2's medical record, a MSW's (medical social worker) note of 11/20/12 states the client was assessed for adjustment issues and the client meets the criteria for admission with a plan for "social work visit 2 x month". There are no further MSW notes nor case conference notes regarding the status of the client. Per interview on 01/16/13 at 12:15 P.M. at 2:30 AM the MSW stated s/he did not follow up with the family or client but spoke to	G 144	G144 Corrective Action Plan: All Clinical staff will be reminded that it is their professional responsibility to document all communication between disciplines by voicemail and by memo. The QI Specialist will complete an audit of 10% of the active and discharge records in February/March, to assure that communication is documented between disciplines and that untoward findings are reported to the appropriate person. Completion date 3/31/2013 POC G-144 accepted 2/7/13 Susan L Emmons RN	

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G 144	Continued From page 2 the Nurse 'sometime in the middle of December and I should've closed the loop but the nurse thought they were doing better, so I was not needed." The MSW confirmed there is no documentation in the client's chart of the reporting and coordination of client services. 2.Per record review on 01/14/13, Client #3 was admitted to services on 11/05/12 for diagnosis of aftercare following musculoskeletal system and long term coagulation use. On 11/05/12, Client #3 was assessed and was to be provided with physical therapy and home health aide services. Per the medical record on 11/23/12 at 1100 AM during a regularly scheduled physical therapy visit, the medical record indicates that Client #3 verbalized to the Physical Therapist (PT) that he/she was left home alone on Thanksgiving and was still alone at the time of the visit. Client #3 verbalized to the PT that he /she was very sad and admitted to being depressed. Client #3 also indicated to the PT that he/she had a history of cutting him/herself. Per review of the medical record there was no evidence that the PT had communicated to the interdisciplinary team (Nursing, Medical, or Social Services.) the potential need for pschycological services of Client #3 after he/she made statements of sadness, depression and a history of cutting behaviors. Per interview with the Clinical Director on 01/14/13 at 3:25 PM, he/she reviewed the notes in the medical record and confirmed that there was no evidence that the PT had communicated the potential need for psychological services for Client #3 to the interdisciplinary team (Nursing,	G 144		

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G 144	Continued From page 3 Medical, or Social Services). The CCC confirmed that the PT should have communicated the potential need for additional services to the IDT team to ensure comprehensive client care.	G 144		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on medical record review, and staff interviews, the agency failed to provide for the needs of 1 of 2 clients (Client # 4) who would benifit from therapy services. The findings are as follows: Per review on 01/14/2013 of the medical record for Client # 4, who had a diagnosis and history of prostatic hypertrophy, Urinary tract infection, and below the knee amputation, the hospital discharge summary dated 04/16/2012 indicates the need for OT (occupational therapy) as stated in the chart note as " needs order for OT to facilitate independence with ADL's (activities of daily living), including toileting and dressing." OT was never ordered . Currently the agency has no occupational therapist available (since July 2012) and this service is provided to clients as an out patient service through the hospital. During the admission of 07/23/12 Client # 4 was seen by Physical Therapy and was discharged from that service on 11/20/2012 with readmission of Physical Therapy services starting on	G 157	G157 Corrective Action Plan: Client #4 was recovering from a Urinary Tract Infection when the visit with the surveyor occurred on 1/14/13. When an elderly client has a UTI, it can be very debilitating as it was in Client #4's case. The nurse reacted appropriately and reinstituted Physical Therapy two times per week and increased the HHA from 2x/wk to 3x/wk to assist the client's recovery. The physician was informed and approved of this change in the Plan of Care. I challenged the surveyor's findings that more needed to be done at this point in his care. As far as provision of Occupational Therapy, we have rehired our previous Occupational Therapist and she will be working a regular schedule in June after her current school contract expires. Until that time, she is willing to work one day per week seeing any clients who are in need of OT services. Completed on 1/17/2013	

POC G-157 accepted
2/7/13 Shawn L. Emmons RN

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G 157	Continued From page 4 01/14/2013. Per the initial nursing assessment of 07/23/2012 indicated that the client was independent with feeding and upper body dressing. Subsequent assessments, dated 11/19/2012 and 01/14/013 noted Client # 4 as having declined to "needing assistance" to being "totally dependent in upper body dressing and toileting", respectively. An assessment note dated 01/14/2013 indicates that this client is "too difficult to move from home to car, and MD makes home visits". Per interview, the Clinical Director on 01/16/2013 at 11:30 A.M. stated that the agency is currently advertising for an occupational therapist and that because OT was not specifically ordered that the agency feels that Physical Therapy might be able to meet the OT needs of Client # 4. S/he confirmed that the medical record and assessments indicated that the resident is too weak as noted by the decline in ADLs to seek therapy on an outpatient basis service to adequetly meet the need of the client.	G 157		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and interview the agency staff failed to provide treatments, including MSW, skilled nursing and physical therapy (PT) visits as ordered by the physician for 3 of 12 Clients in the targeted sample. (Clients # 2 #5 & #6,) Findings include:	G 165	G165 Corrective Action Plan: #1. All MSW referrals will be seen in a timely manner. When a referral is received ordering MSW, she will be notified by the clinical manager and a visit date will be established at that time to reflect timely response. The QI Specialist will audit 100% of clinical records that have MSW ordered for timely visiting over the next two months. Completion date: March 31, 2013.	

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G 165	Continued From page 5 1. Per record review on 01/15/13 , Client #2 did not received a timely MSW evaluation visit as ordered by the physician. The order (485) dated 10/21/12 - 12/19/12 states " MSW 1 x wk/1 start on 10/23/12 to assess social and emotional factors, evaluate and long term plan". Per review of the client's record a MSW visit was noted approximately one month later on 11/20/12. Per interview on 01/16/13 at 12:15 P.M. the MSW stated that ' I work per diem for the agency and when I get a referral, I triage, but I did feel bad it took so long". The MSW confirmed that treatment was not timely as ordered by the physician. 2. Per review of the medical record on 01/14/13, Client #5 was admitted to services related to recent hospital stay for an above the knee amputation. Per review of the recertification assessment completed for the date of 11/01/12 and in the recertification period of 10/09/12 to 12/07/12, the physician wrote orders for physical therapy (PT) services for 2 times a week for 6 weeks and 6 as needed visits. Review of the PT notes dated 11/12/12 indicates that Client #5 had not met all of his/her goals and was still progressing towards them. Per review of the medical record there was no documented evidence after 11/12/12 that Client #5 had received any further Physical Therapy as required by the physician's order dated 11/1/12. Per interview on 01/14/13 at 325 PM the Clinical Director, reviewed the medical record and was unable to provide documentation that indicated that Client #5 received Physical Therapy services per physician orders. The Clinical Director confirmed that the PT should have documented	G 165	G165 Continued from Page 5 Corrective Action Plan: #2. This particular PT client was seen by PT but she failed to document that the client and wife had asked that they no longer visit until requested and that the physician was notified of this request. The professional staff have been reminded (1/17/13) that it is their responsibility to assure that all clinical documentation is current in relation to visit frequency and any changes that occur. The QI Specialist will perform a random audit of clinical records to assure that frequency orders are followed. Completion date: February 28, 2013. #3. The client with no visit during the week of 12/23/12 had requested that the nurse not visit since it was Christmas week and she was seeing the physician on Friday of that week. The nurse failed to document this communication in the clinical record. The professional staff have been reminded (1/17/13) that it is their responsibility to assure that all clinical documentation is current in relation to records to assure that frequency orders are followed. Completion date: February 28, 2013.	

POC G-165 accepted
2/7/13 Susan J. Connor RN

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G 165	Continued From page 6 the reason for and obtained a discontinue order by the physician if services were to be discontinued for Client #5. 3. Per medical record review on 01/14/2013, there is no documentation regarding skilled nursing visits having been made during the week of 12/23/2012 for Resident # 6.. The physician order reads skilled nursing visits 3x wk/2 and 1x wk/7. Per interview with the Clinical director on 01/16/2013 at 1:15 pm, s/he confirmed that there were no visits made to Resident # 6 during the week of 12/23/2012. S/he further states that the family requested no visits during that week but there is nothing in the chart to support this and confirms that this information is not in the medical record.	G 165		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on observation, record review and interview the registered nurse failed to make necessary revisions to the plan of care for 1 of 2 clients in the sample. {Client # 7}. Findings include: 1. Per observation of home care on 01/14/13 at 12:45 P.M. the LNA applied an ointment to the client's reddened leg for which no care plan was noted. Per record review on 01/14/13 at at 2:55	G 173	G173 Corrective Action Plan: During a home visit, the surveyor noted that the HHA applied Bag Balm to a client's legs. It was not a task identified on the HHA plan of Care. On 1/17/13, the clinical Manager alerted all HHA and professional staff that ONLY items on the HHA plan of care can/will be performed when the HHA visits clients. Furthermore, it is the responsibility of the HHA to alert the nurse/therapist if they are being asked to perform functions not on the	

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G 173	Continued From page 7 P.M. Client #7 has a history of ulcers and cellulitis of the legs. The LNA care plan directs staff to perform personal care to include shower, bathing, dressing, assist with transfer, however, it does not direct staff to apply 'bag balm' ointment to the legs. Per interview on 01/16/13 at 9:05 A.M. the Clinical Director stated that the nurse will initiate the care plan with all the areas of care to be provided. The Clinical Director further stated that 'lotion or ointments should be on care plan' and confirmed that the care plan was not revised to reflect the client's needs.	G 173	G173 Continued from Page 7 Corrective Action Plan: care plan and then it is the professional's responsibility to determine if it needs to be added to the care plan. The QI Specialist will perform a random audit to assure that only those duties identified on the care plan are being performed by the HHA. Secondly, the professional staff has been instructed to review the care plan carefully with the client on supervisory visits to assure that it is complete and meeting the client's care needs. Completion date: Audit 2/28/13. Care plan review: ongoing POC G-173 accepted 2/7/13 Susan L. Emmons RN	